Bureau of Quality Improvement Services (BQIS)

Mortality Communication

BQIS

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Mortality Communication Purpose

BQIS is sharing quarterly mortality data with the expectation that providers will use this information to strengthen its training efforts. The following issues were identified during mortality reviews completed during the fourth quarter of fiscal year 2012 (April through June 2012). While the data presented may pertain to comorbid conditions that are not attributable to the cause of death, the risk involved with these conditions warrant further examination. This communication is not intended to provide specific medical recommendations and interested parties should seek further clarification from trained medical professionals.

PALLIATIVE CARE

There was at least one case reviewed by the Mortality Review Committee (MRC) in which the person might have benefitted from palliative care consultation. The following information provides a brief introduction to the concept of palliative care with which providers, case managers, and other interested stakeholders should be familiar.

Many organizations have developed definitions for palliative care. The Center to Advance Palliative Care defines this care as "specialized medical care that focuses on relief of the symptoms and stress of serious illness. The goal is to prevent and ease suffering and to improve quality of life for patients and their families. Palliative care is appropriate at any age and any stage of an illness. And, it can be provided at the same time as curative treatment."[1]

As a point of clarification, palliative care is person-oriented rather than disease oriented.[2] Palliative care may be appropriate for any age. It has a different focus than curative treatment offers, although curative treatment can continue when receiving palliative care. Curative treatment focuses on life prolongation and eradication of disease. Palliative care is also different from hospice care, as hospice care focuses on those in the terminal phase of an illness. In many respects, hospice care is one type of palliative care, focusing on those who are terminally ill. Palliative care, however, is not time restricted, as is hospice care. A person may be eligible for palliative care at an earlier stage of progression of a serious and advanced illness, even when it is not considered terminal.

As mentioned in the definition above, palliative care addresses the many causes of suffering with progressive and advanced disease, including pain, and other physical symptoms (nausea, fever, psychological distress, anxiety, social difficulties, cultural issues, spiritual issues, etc.). Unrecognized or ongoing problems in one sphere of life may contribute to suffering in other domains of a person's life.

To maximize quality of life, optimal palliative care requires team focus on the many known unique aspects of the person, and includes a compassionate approach, cultural awareness/sensitivity, family considerations, consent, discussion, agreement as to the choice of site of care at various stages of disease progression, and excellent communication as part of the team process with the person, with direct support and professional staff, among health care professionals, and with the family/guardian of the person.

For those who are deemed as emancipated adults, identification of a surrogate decision maker is imperative when the person is no longer able to make decisions, or at the start of treatment for those not having capacity to comprehend the decisions that need to be made.

[1] Center to Advance Palliative Care, www.getpalliativecare.org

[2] Manual of Hospice Care and Palliative Care, www.hospicecare.com

Palliative Care (Cont.)

Although continuity of care is best accomplished by keeping the individual in a familiar setting, if moving is required, the agency needs to ensure continuity of all aspects of care, and ensure training is completed for those receiving the individual.

Medicare/Medicaid and other insurance companies have provided guidance concerning when to consider palliative and/or hospice care. Criteria for specific diagnoses have been created to assist in determining whether hospice and/or palliative care would be appropriate. The list of diagnoses and the criteria for each diagnosis necessary in order to qualify for these additional resources of hospice and/or palliative care have changed over time. Selected diseases/diagnoses seen in the IDD population which may benefit from palliative care include cancer, dementia, failure to thrive, and end stage disease of heart, liver, lung, or kidney, among others. It is recommended that the provider agency contact local hospice/palliative care organizations/providers for specific questions and eligibility criteria and how such care would interface with care by the provider agency. Specifically, the provider agency should inquire if and how palliative care could benefit the person. Discussion and guidance from the primary care physician would clarify whether appropriate testing for the appropriate criteria (based on the diagnosis and severity of condition) have been completed, and if the physician interprets the results as meeting those threshold levels for which the person would benefit from palliative care. A hospice/palliative care provider would be able to assist in this process. **As an advocate for the person, the team needs to ensure palliative care is considered and offered, if this is deemed appropriate by the physician (ie., meets Medicare/Medicaid/private insurance eligibility criteria).** At the point of meeting criteria for one of the above diagnoses, other resources from the community may be of assistance to the agency in meeting the person's needs.

Palliative care is especially important in guiding the interdisciplinary team in the home in caring for the person. It usually consists of a team with expertise in palliative care, including physicians, nurses, and social workers, but may include other health professionals. It is one approach to providing additional services to the person with serious illness at a time of increasing need in addition to what is being provided by the provider agency. This may require coordination between the provider agency home staff and the palliative care team. As experts in pain management, this team can additionally assist in teaching and guiding the home staff in caring for the person during this challenging time. The palliative care team may also be able to provide guidance as to whether an alternative setting would be appropriate in care of the person as the health condition declines, or whether other resources in the health system should be considered. The palliative care team is also able to provide counsel and support to the extended family and staff. It is recommended that the provider agency visit one or more of the following web sites as an introductory step in considering the resources available through a palliative care team.

References:
www.getpalliativecare.org
www.hospicecare.com
www.homecarehospice.com/criteria.html
www.caregiverslibrary.org/caregivers-resources
www.webmd.com/palliative-care
http://nhpco.org
http://kindethics.com
http://www.avert/org/palliative-care.htm

Documents are also available on the BQIS website (http://www.in.gov/fssa/ddrs/3948.htm) relative to palliative care. The documents cover the topics of general considerations, pain management, comfort measures, and adaptive equipment.

Urinary Tract Infections (UTI)

As mortality reviews are conducted, there have been a number of people who have experienced urinary tract infections (UTI) in the months leading up to death. While the UTI did not necessarily contribute to death, quality of life was affected. Based on cases reviewed this quarter, the following were determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

Certain populations are at high risk for developing urinary tract infections (UTI). Women tend to be at higher risk of UTI than men. However, anyone with a physical or functional abnormality of the urinary tract (which may not be known until tested/diagnosed) is at risk for UTI. Other people at risk include those with kidney stones, those with diabetes mellitus, those with a urinary catheter in place, those with a history of recent placement of a catheter (from a prior recent visit to the emergency room (ER) or hospital), and men with enlarged prostates/benign prostatic hypertrophy.

Signs and symptoms of health status change due to a UTI can be divided into those due to the local irritation of the infection, as well as signs and symptoms which are more systemic and may not be specific to UTIs.

Urinary Tract Infections (UTI) (Cont.)

Signs/symptoms specific to the UTI include:

- burning/pain on voiding,
- crying or screaming when attempting to void,
- frequently going to the bathroom,
- frequent voiding at night, or
- rubbing the lower abdomen due to discomfort (burning sensation or bladder cramps/spasms).

In addition, staff may notice blood in the urine, cloudy urine, or "strong smelling" urine. The person may be incontinent, when that is not normal for the person.

Less focused and more systemic signs and symptoms include:

- fever,
- chills,
- shakes,
- refusing to eat,
- restlessness,
- increased irritability,
- nausea,
- vomiting,
- unusual/bizarre behavior,
- lethargy,
- falling,
- back pain,
- "just not him/herself," or
- disturbed sleep.

References:

- *http://www.mayoclinic.com/health/urinary-tract-infection*
- *http://www.lifenurses.com/nursing-care-plans- for-urinary-tract-infections-utis/*

It is important to record staff observations when these signs and symptoms occur, along with the time and date. Some people will have the same subtle signs and symptoms each time a UTI develops and recording these observations assists other staff in identifying a UTI at an early stage. It is important to call the agency nurse, house manager, etc., for guidance in contacting the primary care physician (PCP) or other action steps. If fever, lethargy, and vomiting occur, unless directed otherwise by the PCP or other health care professional, it is recommended that the individual be taken to the ER or urgent care center for evaluation and treatment.

If staff notice that the UTI is recurring at periodic intervals, residential staff should be an advocate and document on a log or another easily retrievable document, the symptoms/signs exhibited over time which may indicate recurrent UTIs, or early signs of impending illness from a UTI, and discuss the possibility of a need for further evaluation, as well as preventive measures with the PCP.

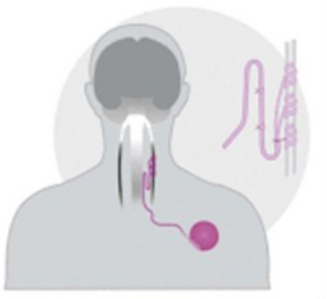
Seizure Management

Vagus Nerve Stimulation (VNS)

As mortality reviews are conducted, there have been a number of people who have had a Vagus Nerve Stimulator (VNS). Based on cases reviewed this quarter, the following were determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

Vagus nerve stimulation (VNS) is designed to prevent seizures by sending regular, mild pulses of electrical energy to the brain via the vagus nerve. These pulses are supplied by a device something like a pacemaker. It also is designed to reduce the length of seizures or stop an impending seizure.

The VNS device is sometimes referred to as a "pacemaker for the brain." It is placed under the skin on the chest wall and a wire runs from it to the vagus nerve in the neck.



michiganneurology.com

Seizure Management (Cont.)

The vagus nerve is part of the autonomic nervous system, which controls functions of the body that are not under voluntary control, such as the heart rate. The vagus nerve passes through the neck as it travels between the chest and abdomen and the lower part of the brain.

The neurologist programs the strength and timing of the impulses according to each person's individual needs. The settings can be programmed and changed without entering the body, just by using a programming wand connected to a laptop computer.

References:

- http://www.epilepsy.com ;
- *Epilepsy Patient's Manual for Vagus Nerve Stimulation with the VNS Therapy System (Cyberonics), December 2008;*
- http://epilepsy.med.nyu.edu/diagnosis-treatment/vagus-nerve-stimulation-vns
- http://www.epilepsy.com/epilepsy/VNS

Holding a special magnet near the implanted device causes the device to become active outside of the programmed interval. For people with warnings (auras) before their seizures, activating the stimulator with the magnet when the warning occurs may prevent the seizure. For seizures which have started, activating the stimulator may help to stop the seizure. Many patients without auras also experience improved seizure control.

When using the magnet to swipe the vagus nerve stimulator (VNS), good documentation is vital. Record each time (date and time of day) it is swiped (how many seconds/minutes between swipes, if necessary) on a seizure log or staff log and the result after every swipe (e.g., the seizure continued, the seizure stopped within a certain number of seconds, etc.). This information can be shared with other staff, as well as the neurologist's office when there is an appointment. The frequency of use and the effect of the magnet swipe is helpful in maximizing care to the person in controlling the seizures. The programming of the VNS Therapy System can be continued or changed based in part on the history of the frequency and effectiveness of the magnet swipes, and the frequency and length of seizures. The information also may indicate to the neurologist's office that further training is needed for staff and/or family members in correct use of the magnet. **Each staff and family member providing care for the person should have training on the magnet swipe, and be able to demonstrate/describe identification of the onset of seizure or aura of a seizure if one exists, demonstrate/describe the correct use of the magnet, and demonstrate the ability to record the number of swipes, time/frequency of swipes, and effect of the swipes, as well as the length of the seizure (time started, time ended, description of seizure activity).**

Depending on how the magnet is programmed, the magnet may be reswiped after 1 or 2 minutes if the seizure continues. The neurologist's office should be able to provide detailed instructions.

Documentation Of Seizure Activity

The number of people with a seizure diagnosis is a data element that is captured as part of the mortality review process. Based on cases reviewed this quarter, it was not always apparent that "best practice" documentation was part of the seizure management program. It is recommended that the following issues be shared with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

Optimal care for seizures (e.g., changes in seizure medication or dosages of seizure medication, lab testing for medication blood levels, other lab testing for side effects of medication, etc.) requires an accurate and complete history of seizure activity. A seizure log in the home is one way to provide this information. Each seizure should be recorded once the person has recovered/stabilized from the seizure (if there are two staff present, one can assist the person as the other staff records information), providing start and stop time, date, a description of the seizure, interventions (e.g., Diastat use, calling 911, etc.), positioning to keep the person safe, and any other information the neurologist or primary care physician (PCP) may request be recorded. If there is suspected seizure activity during sleep, accurately recording what is observed will assist in determining seizure activity. It is important all information pertaining to seizures be recorded on one form that is brought to the PCP's or neurologist's office for review. The information should be legible and easy to understand. An agency nurse or administrative supervisor may be able to assist in developing a user-friendly form which minimizes hand-written notation, but allows complete documentation of critical information.

During a seizure: *(Ictal stage)*
When a seizure occurs, observe and document the following:

a. Date, time of onset, duration
b. Activity at time of onset
c. Level of consciousness (confused, dazed, excited, unconscious)
d. Presence of aura (if known)

Seizure Management (Cont.)

e. Movements
   1. Body part involved
      - progression and sequencing of activity ***(site of onset of first movement is very important as well as pattern, order of progression, or spreading involvement)***
      - symmetry of activity
      - unilateral or bilateral
   2. Type of motor activity
      - clonic (jerking)
      - myoclonic (single jerk of muscle or limb)
      - tonic (stiffening)
      - abnormal posturing movements,
      - dystonia,
      - eyes: eye deviation, open, rolling or closed, eyelids flickering
      - head turning,
      - twitching

f. Respirations (impaired/absent; rhythm and rate)
g. Heart (rate and rhythm)
h. Skin changes
   - color/temperature;
   - pale/cyanotic, (also check lips, earlobes, nailbeds)
   - cool/warm;
   - perspiration/clammy)
i. Gastrointestinal
   - belching
   - flatulence
   - vomiting
j. Pupillary size, symmetry, and reaction to light
k. Changes in sensory awareness (auditory, gustatory, olfactory, vertiginous, visual)
l. Presence of other unusual and/or inappropriate behaviors

A 911 call for assistance is recommended for prolonged seizures (a seizure lasting greater than 5 minutes), or as directed by the person's neurologist or PCP, especially when the seizure protocol includes the use of Diastat), when a subsequent seizure occurs before the person regains consciousness, or when other conditions complicate the situation (the seizure occurred in water, when the person is injured, when the person has diabetes mellitus, etc.).

After a seizure (*post ictal*):
After the seizure activity has ceased (post ictal), record the presence of the following conditions and their duration in the person's record. Continue to assess until person returns to baseline.

a. gag reflex, decreased
b. headache (character, duration, location, severity)
c. incontinence (bladder and bowel)
d. injury (bruises, burns, fractures, lacerations, mouth trauma)
e. residual deficit
   - behavior change
   - confusion
   - language disturbance
   - poor coordination
   - weakness/paralysis of body part(s)
   - sleep pattern disturbance

References:

- *BQIS website (http://www.in.gov/fssa/ddrs/4247.htm)*
- *http://ddsn.sc.gov/providers/manualsandguidelines/Documents/HealthCareGuidelines/NursingMgmtSeizures.pdf*
- *http://www.epilepsy.com/EPILEPSY/Firstaid,*

References:

- *First aid for seizures at http://www.epilepsy.com*
- *http://firstaid.about.com (under strokes and seizure: manage a seizure)*
- *http://ddsn.sc.gov/providers/manualsandguidelines/Documents/HealthCareGuidelines/NursingMgmtSeizures.pdf*
- *BQIS website (http://www.in.gov/fssa/ddrs/4247.htm)*

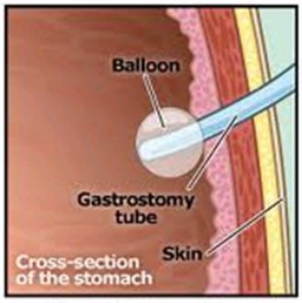
Seizure Management (Cont.)

Ensuring Safety During Seizure Activity

As mortality reviews are conducted, there was at least one case reviewed this quarter where a staff member put an object into the seizing person's mouth. It is recommended that providers, case managers and other interested stakeholders review the following information, share with pertinent team members, and take proactive steps as appropriate.

If someone is having a seizure, nothing should be inserted into his/her mouth (e.g., finger, tongue blade, stick, etc.). This may cause harm to the person and/or the person attempting to assist. There are many informational sources concerning first aid during a seizure which can be found on the internet. Although the tongue may have been bitten and there may be foam or blood around the lips, the person assisting should focus on areas that are in his/her control. These areas include noting the time of onset, helping break a fall, ensuring adequate ventilation, moving hard or sharp objects away from the person to reduce/minimize the chance of injury, loosening clothing, placing a pillow or soft material under the head, remaining with the person and giving verbal reassurance, providing as much privacy as possible, providing other supportive therapy as ordered by primary care provider, etc. As soon as the convulsing has stopped, the person should be turned into a side-lying position. This will help the tongue return to its normal front-forward position and will also allow accumulated saliva to drain from the mouth.

G-/J-Tubes

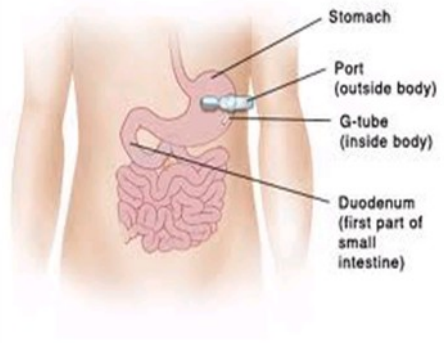


Open Gastrostomy

childrenscolorado.org

This topic has been discussed in previous issues of the mortality review communication and can be found at http://www.in.gov/fssa/ddrs/2635.htm and http://www.in.gov/fssa/files/Feeding_Tubes_7_9_12.pdf. As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate. This quarter's focus includes the following:

The insertion site of a feeding tube (G, G/J, J) requires approximately 30 days for healing to occur. If problems develop at the feeding tube site before then (e.g., redness, bleeding, draining), or the tube comes out partially or completely, then the care plan should provide instruction to the staff concerning what steps to take and how quickly these steps should occur. For new feeding tubes that come out partially or completely within 30 days of insertion, re-insertion should not be done by staff in the home, but should be promptly referred to the ER for evaluation, and insertion. As the ostomy tube site will begin to close quickly, and as inserting a tube in the first 30 days can cause complications, there should be prompt referral to the ER for urgent treatment. Correct placement can be done through radiographic imaging or other direct procedures, with confirmation of correct placement.

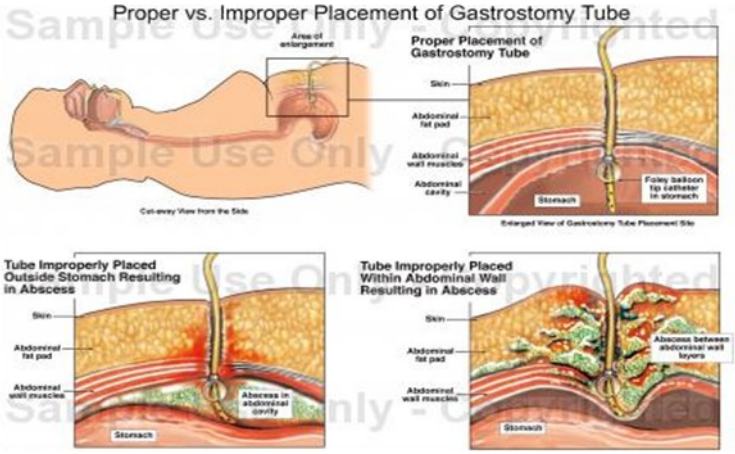


einstein.edu

Once an insertion site/ostomy site for feeding tubes matures, the staff need direction on how to proceed should the tube be dislodged partially or completely. These ostomy sites will also close promptly. The care plan should have clear guidance from the Primary Care Physician (PCP) or specialist who placed the feeding tube as to the steps to be taken, such as sending to the ER immediately, placing a temporary catheter to ensure the ostomy site does not close and send to the ER, etc. The directions in part depend on the expertise of the provider agency staff available as well as the experience of the PCP/specialist with the living arrangement and IDT for the person with IDD. It is important to clarify with the physician the type of staff availability in the home at any time and staff available on call to the home. For many individuals, it is generally not recommended to resume feeding through a replacement tube until the correct position is confirmed by radiographic measures and there is a physician order to resume feedings. This provides assurance to the staff that the tube is in the correct location for

G-/J-Tubes (Cont.)

feeding. However, individual-specific plans may vary depending on the type of feeding tube, the expertise of provider agency nurses, ease of transport to the emergency room (ER), behaviors of the person, etc., and allows the opportunity for the residential staff and interdisciplinary team to work closely with the agency nurse or supervisor and PCP/specialist in developing a successful detailed care plan, as well as measures to prevent dislodgement of the tube from the body.



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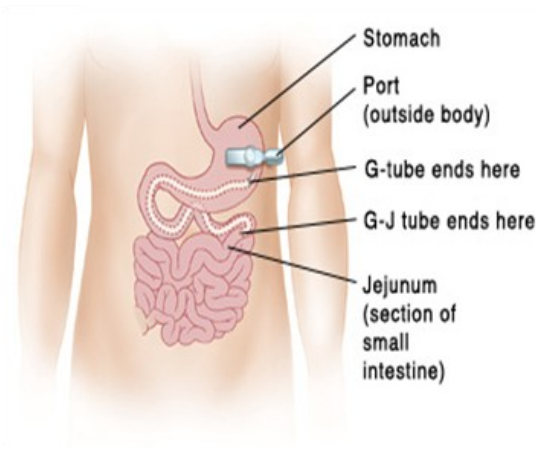


mountnittany.org

References:

- *http://oralcancerfoundation.org/dental/peg_complication_chart.htm (PEG complication chart)*
- *http://oley.org/charts/newHEN.pdf*
- *Malposition of percutaneous endoscopic-guided gastrostomy: Guideline and Management, Journal of Minim Access Surg, S Milanchi, et al., 2008 Jan – Mar; 4 (1): 1-4*
- *State of Connecticut Department of Developmental Services, Nursing Protocol #NP 09-1: Care of Persons with Gastrostomy Tubes: www.ct.gov/dds/lib/dds/health/np_09_1gastrostomy_tubes.pdf*
- *http://www.in.gov/fssa/files/FS_enteral_feeding_tube_problems_20091118.pdf*

Documentation of a Person's Code Status

This topic has been discussed in previous issues of the mortality review communication and can be found on the BQIS.in.gov website. As mortality reviews were conducted this quarter, there was at least one case where the staff person was not sure of the person's code status and was unable to immediately locate the pertinent paperwork for emergency responders. **It is recommended that providers review existing operating policies/procedures, revise them as needed, and ensure staff are knowledgeable about the location of the documents regarding code status. In addition, it is recommended that each person's chart (or location of said document) is checked to ensure the relevant paperwork is present.**

For those who are terminally ill, it is common to have signed documents of end of life decisions completed. However, it is imperative that all staff be in-serviced on the current decisions made by the person/family member/guardian. It is also imperative that staff know where such documents are located for immediate retrieval. Documents should be readily accessible, yet preserve confidentiality. However, when there is a terminal event, EMS may still be called, and during the series of events that occur, it is important for staff not to waste time attempting to locate documents that are expected to be readily available. EMS would need to have these documents to review to immediately determine the person's code status.

References:

- *http://www.in.gov/fssa/files/ISDH_-_Advance_Directives_-_Your_Right_to_Decide.pdf*
- *http://www.in.gov/fssa/files/MR_Quarterly_Report_10_6_11.pdf*

Fall Prevention

National Falls Prevention Awareness Day is observed on the first day of fall – September 22, 2012 to promote and increase public awareness about how to prevent and reduce falls among older adults.

Fall prevention has been discussed in previous issues of the mortality review communication and can be found on the BQIS.IN.gov website. As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

A provider agency should have a low threshold of developing and implementing a fall prevention/risk plan for a person. One fall with serious sequelae (e.g., lacerations, bruises, fractures, etc), may be sufficient to take aggressive steps to prevent a recurrence. One fall without sequelae, but in a person with several significant diagnoses/conditions such as osteoporosis, failure to thrive, diabetes mellitus, polypharmacy, unstable gait, prescribed blood thinners, etc., may also be sufficient to develop and implement a fall prevention risk plan.

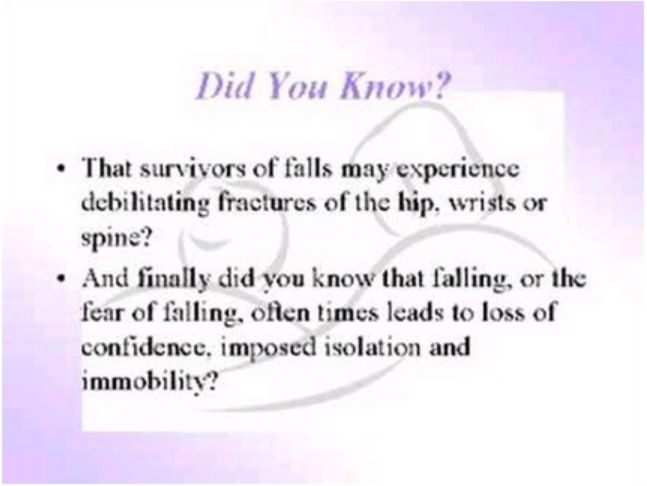
From incident report data, 965 people had a total of 1257 falls with injury reported during this quarter. Of these 965 people, the number of falls per person ranged from 1 fall to 6 falls within this time period.

Table 1. Number of Falls with Injury Reported from April 1, 2012 to June 30, 2012 (obtained from incident data).

Description	April 2012	May 2012	June 2012	Total
Number of Falls with Injury Reported	390	445	422	1257

According to the National Centers for Disease Control Older Adult Falls page:

- One out of three adults age 65 and older falls each year, with the chances of falling and being seriously injured increasing with age.
- Among those age 65 and older, falls are the leading cause of death from injury and also the most common cause of nonfatal injuries and hospital admissions for trauma.
- In 2000, direct medical costs of falls totaled a little over $19 billion.



References:

- https://www.ddna.org/downloads/2012conference/oxxs01_6slides.pdf
- http://www.aota.org/News/AOTANews/Falls-Prevention.aspx
- Fall Prevention Center of Excellence at http://stopfalls.org/service_providers
- http://www.ehow.com/way_5760313_patient-care-plan-fall-prevention
- http://www.mayoclinic.com/health/fall-prevention/HQ00657http://www.mayoclinic.com/health/fall-prevention/HQ00657
- http://www.compassion-homecare.com/include/CHC-FallPreventionGuide.pdf
- http://www.dads.state.tx.us/qualitymatters/qcp/fall/fallswebinarscript-4-30-10.pdf
- http://www.cdc.gov/features/fallrisks/
- http://www.cdc.gov/HomeandRecreationalSafety/images/CDC_Guide-a.pdf
- http://www.psqh.com/mayjun06/falls.html
- http://www.utahsafetycouncil.org/take-safety-home/fall-prevention.asp
- http://www.preventfallstoday.com/ - free copy of Preventing Falls in Your Home
- Falls, Immobility, and Restraints – A Resource Manual, Ann L. Hendrich, Mosby Publishing

There are also documents available on the BQIS website (http://www.in.gov/fssa/ddrs/4247.htm) relative to fall prevention.

Hospital/Rehabilitation Center/Nursing Facility Discharge

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate. This quarter's focus includes the following:

At times, an individual is discharged from a hospital or rehabilitation/nursing facility late in the day, or due to transport time, arrives home late in the day. The provider agency is responsible for the care of the person once the person returns to the home. This requires that staff already be adequately trained and in-serviced on the needs of the person before his/her return home. To assist in a smooth transition, **it is recommended that provider agency staff (nurse, home manager, supervisor) meet with the discharge planner at the hospital/rehab center/nursing facility prior to the discharge to learn of expectations of care and needs of the person.** This provides a window of time for training and updating risk/care plans before the person is discharged. If the agency is unable to provide the training needed for care of the person prior to arrival, the provider agency needs to discuss that with the sending agency. From a hospital setting, there may be the intermediate step of transferring to a nursing or rehabilitation center for further care, or if already at a nursing or rehabilitation center, to delay discharge. The sending facility may be able to provide assistance with training and obtaining interim supplies until the provider agency can order and receive them. Alternatively, one or more staff may be sent to the facility for in-service training to assist in a smooth transfer, who then can train the other staff. If the provider agency is unable to accommodate a new arrival after a certain hour of the day or on weekends, that should be communicated early in the discharge planning process.

References:

- *Several fact sheets regarding hospitalization discharge are available on the BQIS web site - http://www.in.gov/fssa/ddrs/3948.htm*

Building Safety—Fire

Based on cases reviewed this quarter, the following issue was noted at least once and determined to be an issue that would be beneficial to share with providers, case managers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

For people who live independently/semi-independently, assess their ability to respond to emergency situations on their own and take into account what floor they are living on. Options offered should take into account the person's physical and cognitive abilities to successfully evacuate on his/her own. Are there concerns about the person's physical and/or cognitive functioning? Does he/she have a diagnosis of dementia? Is he/she able to use a fire extinguisher? Can he/she see and/or hear if he/she is in a dangerous situation?

If a person lives independently/semi-independently, in addition to completing evacuation drills with assistance, ongoing training should also include successfully completing emergency evacuation drills without assistance.

References:

- *http://www.hrsdc.gc.ca/eng/disability_issues/doc/pfs/guide.pdf*
- *http://www.tdi.texas.gov/pubs/videoresource/qahighrisebldge.pdf*
- *www.nfpa.org/assets/files/PDF/**HighRise**TOC.pdf*

Final Remarks

This communication is designed to enhance the dissemination of functional information that providers, case managers, and other interested stakeholders can use to develop and/or enhance their training programs.